





A Publication of the Department of Personnel & Administration

FOUR LEVELS OF COVERAGE FOR HEALTH & DENTAL AVAILABLE

The State is changing from the current three levels of coverage for health and dental insurance (Employee Only, Employee + 1, Employee + 2 or more dependents) to FOUR levels of coverage - Employee Only (EE), Employee + Child or Children (EC), Employee + Spouse (ES), Employee + Spouse and Child or Children (ESC).

The change to four levels, or tiers as they are commonly called, will be a welcome change for many. Not only is the four-tier structure prevalent among all employers, it is more equitable than the State's current three-tier structure. Currently, an employee who is covering a child under the Employee + 1 tier pays the same as an employee covering a spouse, even though actuarially the cost of healthcare for a child is less than an adult.

The addition of the Employee + Child or Children tier means that an employee who wishes to cover only his or her children will pay a more appropriate amount for that coverage. This tier also accommodates one child or multiple children. This will make it easier for single parents to participate in the State's plan and is expected to reduce the number of State employees with uninsured dependent children. It may also prove to be a savings for families where a spouse has health coverage elsewhere.

When making your open enrollment choices this Spring, be sure to choose the right tier.

FISCAL YEAR 2006 (July 1, 2005 – June 30, 2006)

The upcoming plan year, coverage year or benefit year will be called FY06 for Fiscal Year 2006, as it coincides with the State's fiscal year. It will run from July 1, 2005, through June 30, 2006.

THE INO PLANS

Two of the new Great-West plans available for FY06 (July 1, 2005 – June 30, 2006) will be In-Network-Only (INO) plans. These will be called the INO-30 and INO-40 plans. For those familiar with the current Anthem Liberty plan, these will function much in the same manner. The "30" and "40" refer to the co-payments required for routine visits to the doctor and routine lab work.

The INO plans are exactly what they say they are: In-Network-ONLY plans. This means that they will only pay for the services of doctors and hospitals that are part of Great-West Healthcare's Preferred Provider Organization (PPO) network. If they are not part of the network, you are responsible for paying that doctor or hospital in full. Remember too that you will pay full price in these cases, as providers not in the network do not have discount arrangements (please see "Director's Corner" in this issue).

If staying with your current physician is important to you and your family, then please think carefully before electing one of the INO plans. Do some research. Is your doctor or preferred hospital part of Great-West's PPO network? Check with Great-West Healthcare (www.mygreatwest.com) or ask your doctor. If not, then maybe the INO options are not for you and you may

want to consider one of the PPO options which offer BOTH in-network and out-of-network coverage (please see "More Choices for Medical and Dental Coverage" in the last issue of HealthLine). Be aware that the State, as an employer, has no control over the comings and goings of individual providers, who may leave the network at any time. The fact that a doctor is currently in the network is no guarantee that he or she will remain so throughout the plan year or in future years.

Facts to Know When Choosing INO

- INO plans do not have out-of-network benefits.
- INO plans do not pay for doctors not in the network.
- If keeping my doctor is important to me, I should look at the PPO plans as well, since they offer both in and out-of-network coverage.
- I should find out if my doctor is part of GWHC's PPO network.
- INO plans have higher premiums than the PPO plans.
- INO plans have co-payments for doctors and hospitals rather than deductibles.
- INO-30 has a \$30 co-pay and INO-40 has a \$40 co-pay.

SPRING (OPEN ENROLLMENT) CLEANING

The next open enrollment will be a "positive" enrollment, meaning everyone must participate, as the State would like to do some housecleaning regarding enrollment in many of the benefit programs.

You may find that the enrollment process is a little longer this time around as you are asked questions about your selections. In certain cases, you may be asked to contact your department's benefits administrator to verify items such as common-law marriage or foster children.

You will also be asked to update the beneficiaries for your State-paid basic life insurance of \$33,000, as well as any employee optional life coverage you may have. This will be done through the online system, but may also be done with a paper form that can be downloaded from the web (www.colorado.gov/dpa/dhr/benefits under "Forms"). The rules regarding beneficiaries changed in 2004, and the beneficiaries for the basic life and the employee optional life coverage must be the same, although different percentages can be designated. Multiple primary and secondary beneficiaries can also be designated, but please remember the secondary beneficiary becomes the beneficiary if the primary precedes the employee in death. Remember too that the employee is always the beneficiary for spouse or dependent child coverage.

We are asking that even those who do not want the State's coverage go into the system and actively reject medical, dental, optional life and optional disability coverage. This kind of information provides the State with the data as to whom we are not covering, allowing us to make better predictions for the future, which impacts how the premiums will be calculated. We can also refine the plan options and designs for the future. This is not an attempt to pry into your private lives. Having the best, most up-to-date information is beneficial to the State as it becomes the "insurance company" under self-funding. It is absolutely critical to know whom we are and are not covering.

Additionally, passing accurate information to our vendors, such as Great-West, Delta Dental, Kaiser or Standard Insurance reduces errors. It also reduces costs by eliminating coverage for those individuals who do not meet the State's eligibility requirements. Reducing errors and ineligible coverages saves all of us money when it comes to the costs we'll pay in the coming years. Errors involving dependent coverage can have a more immediate effect as well, leading to denied claims, for which the employee is ultimately responsible.

So please take a couple of extra minutes when going through your open enrollment this time around. The money you save will be your own.

457 PLAN - It's Never Too Early to Save for Retirement

- The average state worker is 43 years old.
- Healthcare costs are estimated to be 30-40% of retirees' costs.
- Most people will require 80-90% of current income to maintain their standard of living in retirement.
- 60% of American employees are not participating in some kind of retirement savings plan.
- Of those who do participate in a plan, the typical investor is only saving \$1500 per year.
- You do the math.

The 457 Deferred Compensation Plan offered by the State is an excellent vehicle for saving and investing additional money for your retirement. The 457 Plan, managed by Great-West Retirement Services, allows eligible employees to save and invest before-tax dollars through voluntary salary deferral. Contributions grow tax-deferred until the money is withdrawn at retirement or other termination of employment with the State.

The 457 Plan is supplementary and does not replace nor reduce your PERA or higher education retirement benefits. Currently, State employees and the State of Colorado contribute to PERA in what is called a defined benefit program, which means that the amount of benefit paid out to you is defined by your age and the number of years of service, as opposed to how much you have paid into it. While PERA is a very good retirement program, it may not always be enough in retirement, especially for those who may not have many service years with PERA.

The 457 Plan offers a wide variety of professionally managed investment options, ranging from conservative to aggressive in risk / return potential. You decide the dollar amount (minimum \$25) or percentage of your salary you want to contribute, as well as deciding which investment options that you believe can help you meet your financial goals. You choose an investment mix that fits your personal investment goals, your investment timeline and your comfort level with risk, or the ups and downs in the value of your investments. For example, if your goal is to accumulate a large amount of money and you have a long time to invest, you might consider riskier investments that have higher potential over the long term.

For simplicity and convenience, you may choose a pre-assembled Profile Portfolio with the 457 Plan. These professionally managed portfolios are mixes of the investment options within the Plan and attempt to match your level of risk with your desired return or growth. There are three Profile Portfolios: conservative, moderate, and aggressive. Not only do these offer convenience, but also diversification.

No one ever complained that they saved too much for retirement. There is no time like the present to start saving. To enroll in the 457 Deferred Compensation Plan, or just to learn more, contact Great-West Retirement Services at 1-800-838-0457 or at www.colorado457.com.

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HEALTH SAVINGS ACCOUNTS (HSAs)

Recently you may have heard a lot about Health Savings Accounts (HSAs). From newspapers to magazines to the Internet, they seem to be the latest and greatest thing in the world of healthcare. HSAs are a mechanism for saving money to pay for current health expenses while saving for future qualified medical health expenses on a tax-free basis. We are pleased to announce that in FY06, the State will offer both an HSA and an HSA-qualified High Deductible Health Plan (HDHP) - the PPO-H plan - that goes hand-in-hand with the HSA.

We did not originally plan to offer an HSA, as we thought the administrative costs would be too high. In our discussions with Great-West Healthcare, they agreed to administer an HSA while keeping the costs down. Great-West will administer both the HSA and the qualified PPO-H health plan. The HSA management will be done through Great West's relationship with Mellon Financial.

While HSAs allow employees to set aside money for medical expenses, employees also decide how that money will be spent and how it will be invested. HSAs differ markedly from Flexible Spending Accounts (FSAs) in what constitutes qualified expenses. Also, unlike FSAs with their "use it or lose it rule" at the end of each plan year, the money in an HSA belongs to the account holder (employee) and can be rolled over from year to year.

Keep in mind that if you are interested in HSAs, you do not have to enroll in the State's established program with Great-West and may explore HSA options outside of the State's offering. But remember that whatever HSA you choose, you must still have an HSA-qualified HDHP. When researching another HSA, be sure that it is registered, that its contributions align with your HDHP medical coverage, and that it has reasonable fees.

There are many ins and outs when it comes to HSAs, too many to discuss in one, brief article. In the coming weeks, please visit our website **www.colorado.gov/dpa/dhr/benefits** for more in-depth information on these products so that you can decide if HSAs are right for you.

FAST FACTS ABOUT THE STATE'S HSA

- MUST be enrolled in PPO-H to participate in the State's HSA.
- CANNOT be enrolled in an HSA and medical FSA at the same time (does not apply to Dependent Care FSA, which are for costs such as day care, not medical costs).
- Maximum ANNUAL contribution is the plan-year deductible amount for the PPO-H, which for Employee only coverage is \$1000, or \$2000 for Employee and any number of dependents, e.g., Employee plus Spouse, Employee plus Child(ren), or Employee plus Spouse and Child(ren). This means the monthly contribution limit is 1/12 of those deductibles. Individuals age 55 or older can make additional contributions directly through Mellon Financial. The additional maximum contribution amount is \$600 for 2005.
- Minimum ANNUAL contribution is \$300, which means the monthly minimum is \$25.00.
- One-time set-up fee of \$10.00, monthly administrative fee of \$3.50
 a month. Total fees for the first year equal \$52.00. These fees will
 be deducted from the HSA itself.
- With the State's HSA design, deductions will be post-tax but contributions can be deducted on income taxes without itemizing.
- HSA deductions will not reduce earnings for PERA calculations.
- Please visit our website, www.colorado.gov/dpa/dhr/benefits, in the coming weeks for more information on HSAs.

Important Information Regarding Full-Time Students and Children Age 19

The move to a fiscal year plan cycle for the State's benefits has many positive consequences. Aligning the components of the total compensation system with the State's budgetary cycle is one example. It also moves the end of one plan year and the beginning of another away from the hectic time of the December holidays.

One consequence though, is how it will impact the dependents of employees. Currently, **once a dependent turns 19 they are no longer eligible to be covered** as a dependent unless they are full-time students. **Full-time students lose eligibility once they reach 24.**

Dependents who turn 19, or student dependents aged 19 to 23 who lose their full-time student status, can remain on their parent's coverage with the State until the end of the *calendar year* in which they turn 19 or lose full-time status. Full-time student dependents turning 24 are only eligible to remain on the parent's coverage with the State until the *end of the month* of their 24th birthday.

These facts will not change in the new plan year, FY06. What the fiscal year cycle will mean is that for those dependents under 24 who lose eligibility, their coverage

will terminate in the middle of the plan year, December 31, 2005.

Parents must be vigilant and take the necessary steps if they do not wish their children to go without coverage. Dependents losing coverage in this manner are eligible to continue coverage with the State's plans under federal COBRA regulations (for more information about COBRA see www.colorado.gov/dpa/dhr/benefits). Keep in mind though, that COBRA coverage is more expensive, as the participant must pay the employee's share of the premium in addition to what was paid by the employer, plus administrative fees. Employees may also want to investigate health insurance through their child's university or college or may want to inquire about individual insurance policies. Please be aware of all that these individual plans may or may not cover, including pre-existing conditions. Do research and ask questions when checking on these plans.

Whatever you do, don't wait until the last week of December to get health insurance for your older children. New options will take time to put in place, especially individual plans that may require medical exams. If you wait too long, you could inadvertently put your children, and family finances, at risk.

KNOW YOUR RIGHTS Jeff Wells, Executive Director

Many of us have had the following experience: We go to a doctor's office or the hospital for a child or for ourselves and we are asked to sign a multitude of forms before we can get any treatment, emergency or not.

These forms usually have provisions like the following:

- We will bill your insurance company for all services provided. You are responsible for any balance due.
- Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept Visa and MasterCard.
- We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits.
 We will bill them, and you are required to pay your deductible or co-payment at the time of your visit.

It is important that you know your rights when agreeing to these types of provisions. Let's review each of these clauses:

We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

Many health care providers have this provision in their documentation, and a few of them even bill you for the "balance due" after they receive a payment from the insurance carrier.

Consider, for example, that you go to your doctor's office and pay the doctor a \$50 co-payment. Later you get a statement from the insurance company that shows the doctor "charged" \$325 for the visit and that the insurance company paid a preapproved amount of \$200.

A few days later you get a bill from the doctor for \$75 (\$325 less \$200 and less \$50). Do you owe this amount? After all you signed a form saying "you are responsible for any balance due."

PROBABLY NOT.

If you are eligible and enrolled in a health insurance plan and the health care service you receive is a covered service under the plan, the participating (in-network) doctor or hospital can only charge the fee negotiated and pre-approved under the contract with your insurance carrier or self-funded employer. In most cases that contract rate is lower than what the provider generally charges. The providers should write off the difference between the charged amount and the approved fee for a covered service and not bill you for the difference.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. This is a critical provision. You must know if the service is a "covered" or "not covered" service. In many ways a service that is "not covered" is treated almost the same as if you had no insurance, and in fact, you are generally liable for the complete charge for the service

Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept Visa and MasterCard.

We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay your deductible or co-payment at the time of your visit.

Our state insurance plans include extensive lists of in-network providers. If you are seeing an in-network provider under a state plan then you will only be expected to pay your co-payment, deductible or co-insurance at the time of your visit.

In most instances there are substantial savings to be had by using in-network providers. The difference can be substantial, as illustrated in the following example:

| BILLED CHARGE | \$12,000 | IN-NETWORK (PARTICIPATING) PROVIDER | OUT-OF-NETWORK (NON-PARTICIPATING) PROVIDER |
|-------------------|---|---|---|
| Allowed Charge | \$9,000 | Of \$9,000¹ You Pay | Of \$12,000 ² You Pay |
| Deductible | In/Network \$1000 Out/Network \$2000 | \$1000 | \$2000 |
| Co-insurance | In/Network 80%/20% Out/Network 60%/40% | \$1,600 (\$8,000 x 20%) | \$2800 (\$7,000 x 40%) |
| Subtotal | | \$2,600 | \$4,800 |
| Balance | | \$0 ¹ | \$3,000 ² |
| Total | | \$2,600 | \$7,800 |

- 1. By contract with the insurance plan, the in-network or participating provider writes off the \$3000 difference between the billed charge and the allowed charge.
- The out-of-network or non-participating provider charges the full billed amount of \$12,000 but the plan only pays based the allowed amount of \$9,000.

While this is only an illustration and is not meant to exactly represent typical savings, it is still clear that using an in-network provider can be substantially less expensive.

You never know when you will be faced with a medical emergency. It pays to plan ahead, to know which hospitals and providers are in your network. Keep your insurance card with you and be familiar with your benefits. If possible establish an emergency savings fund into which you make regular deposits and as indicated above please don't be misled into paying for medical fees that you are not liable for.

Note: This is general guidance only and should not be considered legal advice. For any legal question you should always consult an attorney.

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Rules: Life Insurance & Long-Term Disability

In 2003 the State changed the rules for optional life insurance for employees, spouses and dependent children. While this was well publicized in the open enrollment materials in the Fall of 2002, it is worth reviewing these rules, as they are still in effect. There are other rules for life insurance and long-term disability (LTD) that, while unchanged, bear repeating.

- The spouse of an employee can have **no more than 50**% of the optional coverage that an employee has in \$10,000 increments. For example, if an employee has \$70,000 of optional coverage, the spouse can only have \$30,000. (The State-paid, basic life insurance of \$33,000 provided to all employees is not considered in this calculation.)
- The \$5,000 and \$10,000 amounts for dependent children are also subject to the 50% rule. An employee must have \$10,000, \$20,000 or more in optional coverage to provide the \$5,000 or \$10,000 coverage, respectively. For example, an employee who has \$10,000 in optional coverage can enroll for \$5,000 of coverage for a child, but not \$10,000.
- Employees who fell outside of the 50% rule prior to 2003 were allowed to keep those coverage amounts, being "grandfathered," provided they made no changes up or down to those pre-2003 amounts for themselves or their family. Changes or new enrollments require that a grandfathered employee adhere to the 2003 rules. This has been and will continue to be the rule in subsequent open enrollments.
- New applications for optional life insurance for the employee or spouse are subject to review by Standard Insurance and require proof of insurability.

- "Guarantee Issue" at open enrollment also went away with the Fall 2002 open enrollment. Guarantee Issue means you apply for an amount of life insurance coverage and are guaranteed that amount without proof of insurability, such as a medical history statement. Guarantee issue is now only available when first hired, in amounts up to \$60,000 for an employee and \$30,000 for a spouse.
- Beneficiaries for the basic life and the employee optional life must be the same, although different percentages may be designated. Multiple primary and secondary beneficiaries may also be designated. The employee is always the beneficiary for spouse or dependent child coverage.
- Employees **must** work at least 30 hours per week to be eligible for long-term disability insurance (LTD).
- Employees who are not yet vested with PERA (non-vested) can request that their LTD rates be adjusted when they become vested. If an employee has earned PERA service credit outside of State employment (e.g. a school district), the State will not know when the change in vesting status occurs unless the employee requests the change. (For information on PERA and vesting status visit www.copera.org.)

We know some grandfathered employees experienced problems during the last open enrollment. We have worked to better identify these employees. The process for the next open enrollment will be smoother for both you and the State.

Life Insurance - Age Change, Premium Change

The State calculates its optional life insurance and long-term disability (LTD) premiums based on your age on January 1st of the year. As we move to a fiscal year cycle (July 1 - June 30) for benefits, this could result in increased premiums in January 2006 for some people.

Come January 1, 2006, if your age changes AND you move up in age bands (20-24, 25-29, 30-34, etc.), your life insurance and LTD premi-

ums will increase in January accordingly. For example, if you turn 30 on September 21, 2005, your life insurance premium for \$100,000 of coverage will go from \$8.40 a month to \$10.40 a month beginning with your *January 2006* pay.

Please remember this in the coming open enrollment as you consider or review the life insurance elections for you and your spouse or your LTD elections.

Free Dental Going Away

The free dental insurance provided to employees who chose employee only coverage under the Delta Dental Basic plan will become a thing of the past in the new FY06 plan year. This may be unwelcome to some, but for many this should prove to be a minor concern.

We decided to discontinue the free dental for employee only coverage under Basic for several reasons. While there are certainly employees who used the coverage, many did not. Being a free benefit to employees kept it from appearing on the radar screens for many employees, leaving them unaware of its existence. We can now better use the State's contribution for those who really want this benefit.

By asking employees to pay for the coverage, we hope to discourage those who do not want the coverage from enrolling. As part of the partnership between the employees and the State, it is now in everyone's interest to minimize the costs in our plan. By enrolling only those who want the coverage we do just that. (Please see "Risks and Costs" in the March HealthLine) The State is also able to capture more accurate data on who is covered and how the plan is being used, which can be used in the future to improve the plan's design. This reflects the role the State takes on as the "insurance company" in the self-funded world.

While the free coverage is being eliminated and the State will no longer contribute the full premium amount to the Basic, employee only coverage, it will still contribute a significant amount to this level of coverage. Additionally, this will not impact those with other coverage levels such as Employee + Spouse, Employee + Child(ren), or Employee + Spouse and Child(ren), nor will it impact the Basic Plus coverage. (Please see "Four Levels of Coverage Now Available in Health and Dental" in this issue.)

Great-West Healthcare vs. Great-West Retirement Services

You may have noticed that our current vendor for the 457 Deferred Compensation Plan, Great-West Retirement Services (GWRS) shares the same first name as the new third-party administrator for our self-funded medical plans, Great-West Healthcare (GWHC).

Even though they are part of the same family of companies under the banner of Great-West Life, in their day-to-day operations they are essentially two separate companies. The GWRS personnel involved with the 457 Plan are experts in the fields of investments and supplemental retirement plans. GWHC is an expert in insurance and medical claims in the world of healthcare.

When you contact the 457 personnel they will not be able to discuss health insurance anymore than your banker or investment advisor. Nor will the Great-West Healthcare staff be able to discuss the State's 457 Plan, its investments and their performance.

Great-West Life is a large company with a significant Colorado presence. It is a testament to the quality of their services that two of their branches have been selected by the State to administer two different benefits.

For information on the 457 Plan, contact Great-West Retirement Services at **1-800-838-0457** or on the web at **www.colorado457.com**. Contact information for the Great-West Healthcare team dedicated to the State of Colorado will be forthcoming soon. Currently, you can find information about GWHC at **www.mygreatwest.com**.

HEALTHLINE NOW ONLINE

You can now find this issue of *HealthLine*, as well as previous issues, on our website **www.colorado.gov/dpa/dhr**. Click on the green "Publications and Forms" button to the left.

HealthLine will move beyond its role of open enrollment newsletter to become a year-round educational resource. It will be an important part of our partnership with employees to inform and educate about the world of healthcare.

We know you get a lot of mail, from the State as well as from everyone else you do business with. Plus, postage costs for the State are high. To avoid these costs and to lessen the load on your mailbox, *HealthLine* will soon be available only via e-mail and on our website. Important issues may still be sent to employees' homes in rare instances.

This is a more efficient and simple mode of delivery, which will mean that more people will see and hear our message.

www.colorado.gov/dpa/dhr or call the Benefits Hotline at:

303-866-3434 or 1 800-719-3434 or email the DPA Benefits Unit at: benefits@state.co.us

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